

## CHILD/ADOLESCENT SUBSTANCE USE SELF EVALUATION

Administer to all children 11 years or older. Clinician's judgment as to whether or not it is clinically appropriate to administer when child is less than 11 years old.  
May be administered verbally by clinician or completed in writing by the child.

Date Completed: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: F M

Please mark YES or NO to the following questions:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Do you smoke cigarettes?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. a. Do you currently use alcohol, marijuana, inhalants or other drugs?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Have you ever used alcohol, marijuana, inhalants or other drugs?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Do you use alcohol or drugs on weekends with friends?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you use alcohol or drugs when you are alone?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. Have your parents ever caught you using alcohol or drugs?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. Have you ever left school to use alcohol or drugs?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Have you ever been under the influence of alcohol or drugs while at school or work?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Have you ever woken up and not remembered any of or only a portion of the previous night's events after using drugs or alcohol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you ever driven a car or motorcycle while under the influence of drugs or alcohol?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Have you ever had more alcohol or drugs than planned?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. Have you ever felt the need to cut down or stop completely your use of drugs or alcohol?                                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 12. Have friends ever suggested you might have an alcohol or drug problem?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 13. Has anyone ever sought professional help for you due to your use of drugs or alcohol?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 14. Have you ever lost a boyfriend / girlfriend / close friend because of your alcohol or drug use?                                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 15. Are you using more alcohol or drugs than you used to?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name:

MIS #:

Agency:

Prov.#:

Los Angeles County - Department of Mental Health

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